Care Quality Commission

Magnum Care Limited

Aberry House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 19 and 20 January 2015 and was unannounced.

Aberry House provides accommodation and personal care for up to 38 people accommodated over two floors. This includes care of people with mental health or physical health needs. The majority of people were living with dementia and a number of people received nursing care in bed. On the day of the inspection 32 people were using the service.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. We found that the registered manager was not in day-to-day charge of the home. This was delegated to two managers. One manager was in charge of the nursing care and the other manager was in charge of the residential care. These managers told us they were intending to make applications to become the joint registered managers of the service.

At our last inspection on 4 February 2014, we asked the provider to take action to make improvements. We found

Summary of findings

that appropriate arrangements were not always in place to manage the risks associated with the administration of medicines. At this inspection we found that improvements had been made.

Risks associated with people's health and care needs had not always been fully assessed to ensure that people received care that met their individual needs in order to maintain their health.

The provider supported staff with some ongoing training and development. However, comprehensive training had not been provided to all staff, relevant to meeting the needs of all people who used the service.

People received their medication as prescribed by staff who were appropriately trained and their medication was stored safely.

Staff had received training on how to protect people who used the service from abuse or harm. They demonstrated they were aware of their role and responsibilities in keeping people as safe as possible.

People told us a range of activities were available and that they were encouraged to maintain relationships with people important to them. Relatives and some staff told us that additional activity equipment and activities were needed for people living with dementia.

The Mental Capacity Act (MCA) is legislation that protects people who may lack capacity to consent to their care and treatment. We found examples where the staff team which informed us that people's capacity to consent to specific decisions had been assessed appropriately.

People who used the service had their dietary and nutritional needs assessed and planned for. People told us that they received a choice of what to eat, however on occasions hot meals were served too cold.

People who used the service and relatives told us and our observations showed that staff were caring, compassionate and respectful. People's dignity and privacy was maintained. And staff were available at the times people needed them.

People who used the service were able to participate in discussions and decisions about their care and treatment provided.

Staff spoken with had a good understanding of people's care and support needs, however people who used the service had not always been asked to share information about what was important to them about how they wished to have their needs met. This included information about routines, preferences, interests and hobbies.

The provider had internal quality and monitoring procedures in place. Whilst issues had been identified, it was not clear whether actions had been planned to address these.

The managers enabled staff to share their views about how the service was provided by staff meetings and supervision.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 . You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments to minimise risks to people's health were not comprehensive. Care was not always delivered in a way that promoted people's health and welfare.

People told us they felt safe at the home. Staff were aware of how to report safeguarding concerns to relevant agencies.

Staff were available at the times people needed them.

People received their medicines at the right time and their medicines were stored safely.

People's safety was promoted because, overall, safe staff recruitment procedures were followed when staff were appointed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provision of training required improvement to ensure staff had the up to date skills and knowledge they needed in order to meet people's needs.

Staff obtained people's consent before supporting them. They understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and ensured people's human and legal rights were respected.

People told us that they had a choice of meals and that the quality was good though some people thought food was not always hot. People were provided with appropriate assistance and support and staff understood people's nutritional needs.

People were supported to access health care services. The service worked effectively with health professionals.

Is the service caring?

Good

The service was caring.

People and their relatives told us that they received kind and compassionate care. This was confirmed by our observations.

People's dignity and privacy was maintained.

People and their relatives told us they were involved in decisions about their care.

Staff engaged and communicated well with people.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff had a good understanding of people's needs, however care plans did not always provide guidance for staff about how to meet people's individual care needs and provide support in the ways people preferred.

People told us a range of activities were available and they were encouraged to maintain relationships with those important to them. Relatives and some staff told us that more activity equipment and more activities were needed, in particular for people living with dementia.

Procedures were in place to ensure that complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had systems in place for monitoring the quality of the service. However it was not always clear whether plans were in place to address issues identified.

Staff told us that they received good support from the managers.

Further development of the systems in place to obtain people's views about the quality of service provided was needed.

Aberry House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 January 2015 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with the managers on the residential and nursing sides of the home, five care staff and the cook. We also spoke with seven relatives and nine people who used the service. We observed the lunch time meal service. We spoke with two health professionals and social care commissioners who were monitoring the service.

We looked at five people's care records and other records which related to the management of the service such as training records and policies and procedures.

We spent time observing care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

At the last inspection on 4 February 2014, we found that appropriate arrangements were not always in place to manage the risks associated with the administration of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we found the provider had made improvements. People told us they had received their medication at the prescribed times and that staff explained their medicines to them. We checked medication systems and found them to be well managed. Medication was given to people at the correct time and in the correct dosage. We found medication was kept securely.

Each person had a range of risk assessments in their plans of care, including pressure sore risk, nutritional risk, fall and bed rails. These identified the action needed to reduce the risk to the person. However, we found that care provided did not always reflect the actions identified in these. For example, although pressure relieving equipment was in use for people at risk from pressure ulcers, from the records we saw, repositioning of people had not always been carried out at the stated assessed frequency. We saw a care plan for a person who needed their position changed every two to three hours to prevent pressure sores developing. However, at times the records showed that care was provided to the person over fours hours after the previous care intervention. We discussed this with the managers who stated that the information in this person's care plan was incorrect and that the frequency of re positioning should be every four hours. However, despite this, they agreed that on occasion support was not provided at the required frequency.

Care plans had been written about the risks associated with people's health and care needs. A person with diabetes had an individual risk assessment which identified the risk of hypoglycaemia (low blood sugar) and the requirement to measure the person's blood sugar levels four times a day. Whislt this was being undertaken, there was no guidance for staff on the action to take if the levels were outside acceptable limits for the person. This meant that the person was at risk of unsafe or inappropriate care and treatment in the event of hypoglycaemia.

We observed an unsafe moving and handling transfer as staff had applied pressure to a person's back in order to support this person as they was unsteady on their feet. This meant that there was a risk of this person or staff sustaining an injury. We discussed this with the managers who told us that they would review the moving and handling risk assessments of people who used the service.

Within the record of accidents and incidents involving people who used the service we saw that a person had fallen and had sustained a head injury. Whilst this person had been assessed and observed by the staff team the managers agreed that in these instances external medical assistance should be sought in order to check whether the person required medical treatment.

We found that proper steps had not always been taken to ensure that risks associated with the safe use of equipment had been reduced. This was because a staff member told us that two wheelchairs were still in use, despite there being faults to their brakes. We discussed this with the manager who advised that action was being taken to rectify this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff were present in lounges observing people using the service and keeping them safe. They were alert to potential risks and took steps to ensure people's safety. For example, a person was persistently leaning forward in their chair to the extent they could have overbalanced and fallen. Staff encouraged the person to lean back in order to promote their safety.

People we spoke with told us that they felt safe and would speak to the staff or manager if they had any concerns. One person said, "Yes, I do feel that I am safe here." The provider had safeguarding policies and procedures in place. These were designed to protect people from harm. Staff we spoke with had a good understanding of their responsibilities in relation to protecting people and told us they would immediately raise any concerns with their managers. They told us that they were confident that the management team would then take action to report the concerns raised. If not, staff knew of relevant agencies to report their concerns to.

Is the service safe?

People who used the service told us that they felt there were enough staff on duty to care for them in order to meet their needs. They told us that their call bells were answered quickly. One person said, “I fell over once and I pressed my buzzer and staff came very quickly.” Most staff members told us that there were enough staff on duty to meet people's needs. However, we saw a comment from a staff member in the minutes of the last staff meeting who had raised that because people's needs had increased more staff were needed in the afternoon period. We raised this with the managers who told us that they would review the staffing ratio at this time of the day.

On the day of the inspection we observed that although staff were busy, they were available and able to provide care and support to people in a timely manner.

The nursing manager told us that there was a registered nurse on each shift and the manager was in addition to this. They told us that the provider used agency nurses when necessary in order to maintain the nursing staffing levels. They told us that the agency supplied a small number of nurses who knew the home and the people who used the service well.

Staff told us they had followed various recruitment procedures as part of their recruitment to the home. This included completion of an application form, interview, and criminal records check. We looked at three staff files and found recruitment processes, designed to keep people safe, had mostly been followed although one record showed a reference which was not from the manager of the person’s previous employment. The managers stated this would be put in place for the future to ensure a more robust system.

In the event of an emergency, a “grab” sheet with essential information about each person was kept in their care record and in an emergency folder. This included a personal evacuation plan giving details of the support the person required and the means of evacuation. It also provided information about the needs of the person for other professionals if they went into hospital.

We saw that a fire door had been wedged open, potentially compromising fire safety, so we looked at fire records. Fire alarm tests had been carried out at the required frequency. A fire evacuation had recently been carried out. However, as there were no detailed records of fire drills we could not see if all staff members had participated in evacuations. The managers stated records would show this in the future and that fire doors would be kept shut unless a fire risk assessment showed this risk could be managed.

Is the service effective?

Our findings

Staff told us they thought the training provided equipped them to provide good care to people who used the service. However, staff training records showed that although staff had received training in a number of areas not all staff had received training in all of the areas as deemed required by the provider in order to meet people's needs. For example, not all staff had undertaken training about challenging behaviour, care planning and nutritional screening, catheter care, dementia and visual impairment. Training about people's health conditions , for example, Parkinson's Disease, mental health conditions, stroke, epilepsy and diabetes were not included in the training programme. In addition, training specialist training for nurses in order to promote their personal development was not provided. This meant that there was a risk that the staff team may not have the latest knowledge and skills in key topics needed to deliver safe and effective care. We discussed this with the managers who advised that the provider's training programme would be reviewed and sent us information about further staff training planned.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supervisions and appraisals were used to support staff where they could discuss any issues about their role, and to develop their skills and knowledge. Managers told us that staff training needs would be reviewed as part of this process. They also told us that they observed staff carrying out personal and nursing care in order to check that staff were competent to undertake their roles and deliver care and support in a safe way. Staff told us that they felt supported by the managers in order to fulfil their job roles.

Staff told us that daily 'handovers' took place so that staff could update the next staff on shift about people's needs and if any changes in their care had been identified. Staff we spoke with told us the handover was a good source of information and helped them to meet people's needs. We saw that a written handover was produced for staff to refer to.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The manager and staff team had a good understanding of MCA and DoLS and their role to protect the rights of people using the service. Staff knew the procedure to follow where they suspected a person's liberty could be deprived. We saw that people had access to an 'independent mental capacity advocate' to support people about their best interests. At the time of our visit we noted that the recommendations of authorised DoLS were being followed.

Care records showed that the principles of the MCA Code of Practice had been used when assessing people's ability to make decisions. We saw that mental capacity assessments had been carried out. The MCA (2005) is a law which provides a system of assessment and decision making to protect people who do not have the capacity to give consent themselves. That showed that people's choices and independence was promoted.

Resuscitation documentation was kept in an emergency grab folder which was kept in the office. There was evidence within aperson's care records that the documentation had been completed by the person's GP and the decision had been discussed with the person and their relatives and their views had been recorded. Another care record only recorded the involvement of the GP in making the decision without evidence of involvement of the person or their representative. We discussed this with the managers who stated that they would follow this issue up to ensure that all relevant people were involved in this decision.

People told us that, overall, they enjoyed the meals provided at the home. They told us that there was plenty of food and that it was of a good quality, however all of the people we spoke with told us that sometimes the food was cold or "Not as warm as it could be." They said it depended on whether or not you were served first. We observed some of the food such as the porridge at breakfast time was served from a large bowl on a non-heated trolley and this could have led to the food cooling before it was served. The managers stated this would be followed up and monitored.

People told us there was a choice of two main courses at lunchtime and that they were asked to choose from the menu in the morning for that day. People also confirmed that if they did not like the food offered the cook would prepare something else for them. People did, however tell us that they had not been consulted about the menu

Is the service effective?

choices offered and they had not been asked to identify their preferences in relation to meals provided. We discussed this with the manager who told us that they would follow this up.

The menu showed that a variety of meals were offered however food records did not specify the meals provided to people who had a vegetarian diet. This meant that we could not determine whether a sufficient variety of foods were offered to people who chose to have this type of diet. We discussed this with the managers who advised that they would ensure that records of this would be kept in future.

One person who required a diabetic diet told us that they had a limited choice of suitable desserts available at lunchtime. They told us that as a result of this they normally had cheese and biscuits because the desserts served were high in sugar. However, they said one of the cooks was very good and would ask them what they would like and prepared anything they asked for.

We saw that people were weighed regularly, however their care records did not include information about what action would be taken if they had gained or lost a significant amount of weight. The managers stated this would be recorded in future to show that referrals had been made to the relevant health care professionals.

We looked at the care plan for a person who had diabetes. This stated that the aim was to support the person to have a healthy diet, however staff informed us that the person liked less healthy food options for desserts. This person's care records did not include a nutritional assessment or guidance for staff about how to support this person with healthy food options. We discussed this with the managers who stated that a review of this person's nutritional needs would be undertaken.

People told us they were supported to maintain their health and had access to health care as and when required. Care records also confirmed that they received health care support from a range of health care professionals, which included the community tissue viability nurse, a speech and language therapist, diabetes specialist nurse, GP, optician and dentist. Recommendations and advice from these professionals had been included within the person's care plan.

The managers told us that they were looking to make the living environment more stimulating for people with dementia. For example, to have themed corridors such as seaside scenes, local history, and shops from the past so that people could identify with them and generate topics of conversation and reminiscence.

Is the service caring?

Our findings

People we spoke with told us that all the staff were kind, caring and helpful. One person said, “It is great. Staff know how to look after you.” Another person said, “They are very gentle with me.”

Staff told us that they had built up good relationships with people who used the service and knew what was important to them. We observed staff engaged people in conversations during the day, about topics they were interested in. For example, we heard staff talking with one person about football and another about the imminent visit of their relatives. Another staff member talked to people about their families and holidays they had been on in the past.

We observed many examples of positive caring practice. For example; a staff member assisted a person to sit in their chair at their pace, a staff member sat down and chatted to a person about the book they was looking at and a staff member got a cardigan for a person who did not appear to be warm. The person was then offered a choice of which cardigan they wanted to wear. A staff member asked a person if they wanted a blanket on their legs to keep them warm and chatted with them about their home town and family. We also observed staff talking with people in a calm manner whilst helping them with their meals at their own pace. We did, however observe one staff member to be very directive in dealing with a person. We discussed this with the managers who told us that they would follow this issue up with the staff member concerned.

People we spoke with and their relatives told us that they were involved in making decisions about their care and were offered choices about their day to day lives. For example, they told us that they were able to choose when they got up, when they went to bed and what they wanted to wear. People also told us that they could choose whether they wanted to participate in activities. People told us that staff encouraged them to retain their independence. One person said, “I want to be independent and staff let me do what I can for myself and only help me when I need it. They are very kind.”

We observed that staff communicated well with people and explained what they were going to do before undertaking care tasks.

People told us staff protected their privacy when supporting them with personal care, they said staff always knocked on their bedroom doors before entering and checked with them about their needs and wishes. Information in care plans included reference to steps to be taken to preserve people’s privacy and dignity during their care and support and we observed this to be the case.

We saw that advocacy services were accessed for people if they needed help to make their views known. People told us their friends and relatives could visit them at any time and staff always welcomed visitors.

Is the service responsive?

Our findings

People's care records showed that their needs were assessed prior to admission to the home. This was to ensure that their individual care and support needs could be met at the home. However, this information was not always used to complete more detailed assessments to provide staff with the detailed information needed to deliver appropriate, responsive care, that met their individual needs and preferences. For example, a care plan for a person who had been identified as requiring assistance with continence did not provide staff with instructions about how often they were to support this person to go to the toilet. This meant there was a risk the person was not being taken to the toilet as often as they needed to be. This could impact on the person's health and dignity. The manager told us that they would review this person's care plan to ensure it included specific instructions for staff about how to meet this person's individual care needs.

We spoke with three staff members about people's preferences and needs. They were able to tell us about the people they were caring for and had some information about what people liked and disliked. People who were able to communicate their preferences told us that they were given choices about their daily lives. However, there was a risk that people's preferences may not be known for people with limited communication. This was because care plans contained little information about people's preferences.

People who used the service and their relatives were involved in care reviews. This provided them with an opportunity to put forward their suggestions about the care provided.

People told us that there were a range of activities for them to participate in which they enjoyed. This included physical exercises, quizzes, going for walks and occasional trips outside the home. During the inspection we observed people engaged in a quiz.

We received comments from staff and relatives that there needed to be more activities, particularly for people who occupied the middle lounge of the home. We also discussed with managers the need for activities for people living with dementia. They said they were due to look into this provision and to provide equipment such as tactile equipment and memory boxes for people with dementia.

People told us that they were not sure how to make a complaint. They said that if they had a complaint or concern they would speak to a care worker but they would not know what to do if it was not addressed. One person said, "I suppose I would have to put up with it." The provider's complaints procedure was displayed in the front entrance of the home. We discussed people's feedback with the manager who told us that they would ensure that people were reminded of how to make a complaint.

The provider's complaints procedure identified that people could complain to the management team and included information about how to raise concerns with the ombudsman if necessary. However, it did not give details of the lead authority for investigating complaints. The manager said the procedure would be amended to include this information and take out the reference to the Care Quality Commission investigating complaints, which is not a legal duty of the Commission.

We looked at information related to complaints that people had made. We found that the issues had been recorded and followed up. With regard to one complaint, the management team had provided weekly updates to relatives about a person's care. We noted that a system to capture people's and staff members' concerns was not in place. We discussed this with the managers who agreed that this would be a good idea. They subsequently produced a form to capture such issues and any actions taken in response to these.

Is the service well-led?

Our findings

A registered manager was in post, however this person was not present on the two days of the inspection. The current residential and nursing managers told us they carried out the day-to-day management of the home and assisted with the inspection. They said it was the intention of the provider for them to become the joint registered managers of the home. All of the staff we spoke with said that the managers were very supportive and available to speak to with regard to any issues they had. One member of staff told us, "I feel that I can go to the manager if there is anything bothering me." They also told us that the managers had strong emphasis on ensuring that people's welfare was protected and promoted.

The minutes of a recent staff meeting identified that there was dissatisfaction amongst the staff team in relation to some elements of how they had not felt supported by the provider of service. Managers said they would discuss this with the provider to see whether any action could be taken to improve staff morale in regard to these issues.

Systems in place to obtain feedback from people about the quality of service provided were limited. Group meetings involving people who used the service took place, although not regularly. Service satisfaction questionnares had not been distributed to people in order to obtain their views. We discussed these issues with the managers who stated that they would introduce a service satisfaction questionnaire for people to complete and ensure that group meetings were held more regularly. We noted that a questionnaire had been distributed to relatives of people who used the service and their feedback had been analysed with actions in place to meet the small number of issues that had been raised.

Accidents had been recorded, but there was no analysis of individual accidents and incidents in order to identify trends and themes so as to learn from incidents and accidents. This meant there was a risk that staff would not learn from these situations in order to help to prevent and reduce the potential harm to people. We discussed this with the managers who told us that they recognised that this was an issue and advised that this would be carried out in the future.

There were other quality assurance and audit processes in place, such as checks on medication, the premises and plans of care. These showed that the management team had identified a number of the issues we had identified during our inspection . However, although issues had been noted, there were no action plans in place to show what actions were being taken to address the issues raised. The managers told us that they would address this issue.

We spoke with health professionals about how the management team and staff worked with them. They told us that this had been positive and they had no concerns about any joint working with the service. Commissioners of the service told us that they had raised some concerns about care practice and that they had worked with the managers to ensure people's welfare was promoted. They told us that they continued to monitor the quality of the service provided.

We saw that some aspects of the premises needed repair and maintenance. For example, a number of bedrooms and corridors had scuffed paintwork. However we noted that a small number of bedrooms had been refurbished and the managers told us that this was on-going. In the main shower room, the base of the shower was marked, the door was not in place and there was a gap between the edge of the base of the shower and the flooring, making cleaning difficult and increasing the risk of infection. We were told it was on the maintenance list for replacement but there was no information in the maintenance book to indicate the timescale for this to happen.

During the inspection we noted that the provider had notified the local authority about a safeguarding incident, however we had not been informed about this. The provider has a legal duty to report such incidents to both CQC and the local authority. The manager apologised for this omission and stated that all such incidents would be reported to us in the future. Since the inspection we have received relevant notifications from the managers.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not protected people against the risk of inappropriate or unsafe care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured that persons employed had the appropriate training to enable them to carry out the duties they are employed to perform.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.